Medicaid Information Bulletin
for the
Non-Traditional Medicaid Plan

April 2005

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BULLETINS BY TYPE OF SERVICE

NON-TRADITIONAL MEDICAID PLAN SECTION ON-LINE

When the NTMP Section is updated, the on-line version will also be updated. Providers can obtain a copy of an updated page, or the entire NTMP Section, by using the web site or by contacting Medicaid Information. When pages are updated, the revision date appears at the top of the page. The change is typically marked in the left margin of the page with a vertical line.

The Medicaid Provider's web site http://health.utah.gov/medicaid/html/provider.html has a link to the NTMP Section. The link is a heading in bold print. Or go directly to www.health.state.ut.us/medicaid/ntmp.pdf

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05 - 72 Physician Services, Updated: Chapter 2 - 9, Physician Services

Noncovered code

Under Medicaid only with prior authorization the following code will be open, but it will remain non-covered in Non-Traditional Medicaid:

33619 Repair of single ventricle with outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (i.e. Norwood Procedure) Written Approval . . . . . Criteria #28

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World Wide Web: http://health.utah.gov/medicaid/

Medicaid Information
- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
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05 - 73 Pharmacy Services, Updated: Chapter 2 - 19, Pharmacy Services

The NON-TRADITIONAL MEDICAID (NTM) Section, Chapter 2-19 Pharmacy Services, has been updated. This update clarifies the seven prescription Drug Utilization Review trigger in chapter 2-19.1; provides the program explanation for when injectable therapies may be used post hospital discharge under sub-heading 2.a, Exclusions and Restrictions and clarifies the exclusions for specially formulated products under sub-heading 2.e; enlarges and updates the list for drugs with cumulative monthly amounts to include drugs previously not listed; deletes subheading 2-19.5, Over the counter drugs and medication: OTC Approved Products. The online version of the NTM Provider Manual on the Medicaid Website http://health.utah.gov/medicaid/pdfs/ntmp.pdf includes these revisions.

For your convenience, below is the revised text for Chapter 2-19. The clarifications are underlined in the text.

2 - 19 Pharmacy Services

The Medicaid Pharmacy Policy as set forth in the Utah Medicaid Provider Manual for Pharmacy Services for is hereby adopted for the Non-traditional Medicaid group of clients with the following changes. Coverage is more restrictive for units and time. Pharmacy services include prescribed drugs and preparations provided by a licensed pharmacy. The fact that a provider may prescribe, order, or approve a prescription drug, service, or supply does not make it an eligible benefit, even though it is not specifically listed as an exclusion. The following pharmacy benefits and restrictions are incorporated into this program.

1. Drug Limitations and Benefits

a. Seven prescriptions or more per client per month triggers a Drug Utilization Review for Medicaid Recipients.

b. The co-pay per client per prescription is $2.00 for name brand or generic products.

c. There is no maximum co-pay, i.e., seven prescriptions will require a $14.00 co-pay which is due and payable prior to dispensing the prescription.

d. Prior approval and the criteria governing such are the same as the regular Medicaid program.

e. Generic products with an A B rating are mandated for dispensing.

2. Drug Product Exclusions and Restrictions

a. Injectable products are not available for payment. This includes but is not limited to Zofran, Kytril, Anzemet, Enbrel, Kineret, Insulin pens, cartridges, pre filled syringes, Lovenox, Fragmin or Heparin. When necessary, injectable therapies may be continued for thirty (30) days, by approval, upon discharge from a hospital. Insulin in 10 ml vials will be covered.

b. No duplicate prescription will be paid for lost, stolen, destroyed, spilled or otherwise non-usable medication with some exceptions.

c. No compounded prescriptions covered.

d. No lozenges, suckers, rapid dissolve, lollipop, pellets, patches or other unique formulation delivery methodologies developed to garner "uniqueness" will be covered, except where the specific medication is unavailable in any other form (Duragesic and Actiq -see chapter 2-19.3, Cumulative amounts). Oral formulations limited to tablets, capsules or select liquids.

e. Drugs are covered for labeled indications or Drug Utilization Review (DUR) Board approved indications **only**.

f. Specific classes of drugs are excluded by OBRA 91 statue.
   (1) Cosmetic preparations
   (2) Minerals
   (3) Patches
   (4) Vitamins, except prenatal
   (5) Weight gain or loss

3. Cumulative Amounts of Certain Products for 30 Days include the following:

a. Celebrex - 60
b. Bextra - 30
c. Carisoprodol (Soma) - 120
d. Sedative-Hypnotics - 30
e. Oral APAP/narcotic combinations - 180
f. Methadone any strength - 150
g. Actiq - 120
h. Duragesic 25, 50, & 75mcg - 15
i. Morphine long acting formulations, any strength - 90
j. Oxycontin or generic, any strength - 90
k. PPIs - 31 with prior approval for override.
l. Stadol NS - 10ml (4 vials)
m. Tryptans (for migraine headache) - 9
n. Ultram and gerenrics - 180
o. Ultracet 180 (focus on APAP, therefore included in oral APAP/narcotic 180 cumulative limit)
p. Viagra, Cialis, Levitra - 5
q. Miralax - 1054 gm
r. Lactulose - 1800ml

There are no "grace" periods to obtain the above drugs early. They are available only at 30-day intervals. For Long-Acting Analgesics for a Cancer Diagnosis, the correct ICD.9 code waives the limits.

4. Prior Approval Products

Same as Medicaid Drug Criteria and Limits List, included as a special attachment in the Utah Medicaid Provider Manual for Pharmacy Services and also for Physician Services.

05 - 74 OTC Drugs List Attachment added: Chapter 2 - 19, Pharmacy Services

The OTC Drugs List has been removed from Chapter 2-19.5, and updated and added as an attachment. This List has been updated for all three Medicaid programs into a single table for convenient reference. For your convenience, below is the revised list:

OVER-THE-COUNTER DRUG LIST

Coverage of over-the-counter drugs (OTC) is outlined in SECTION 2 of the Pharmacy Manual, Chapter 2-4, *Prescribed Over-the-Counter Products*. In summary, OTC's are covered ONLY when (1) on the Medicaid OTC list and (2) ordered on a written prescription. OTC products may also have restrictions indicated on the chart which include the following:

Brand name allowed: Brand names are covered only when so noted.
Generic equivalent only: Only the generic equivalent of the brand is covered.
Limits: Limits and other criteria may be noted after the drug name.
NH: Drugs marked 'N H' are reimbursable for patients who are residents of a long term care facility such as a nursing home. When the restriction applies to a drug, all dosage forms apply.
NTM: Item is covered under the Non-Traditional Medicaid program.
PCN: Item is covered under the Primary Care Network program.

Rebate Agreement**:** Manufacturers must sign a rebate agreement with CMS before coverage is allowed. Many generic companies and most house brands have not signed this agreement.

Use the 11-digit NDC Code for billing.

Drug Name	Brand Covered	Limits	N H	NTM	PCN
acetaminophen				–	
alcohol swabs					
antacid liquid and tablets		- Tums rolls, covered - Tums -500, E-X, and Ultra NOT covered - Mylanta NOT covered		–	
aspirin including enteric coated, buffered				–	
Axid AR	yes	(package ≥ 30 tablets)	–		
Benadryl . . . . . generic equivalent only		generic equivalent only	–	–	
Benadryl Allergy Decongestant	yes		–		
Benylin . . . . . generic equivalent only		generic equivalent only	–		
bisacodyl tablets and suppositories				–	
calcium tabs		oyster shell not covered	–	–	
chlorpheniramine			–		
citrate of magnesia		600 ml, maximum	–		
Claritin OTC NDC11523716005; Syrup 115237160301; Claritin-D OTC NDC 11523716203; 11523716202; generic NDC 24385047165;00781507701; 00904562352; loratidine-D NDC 24385035152	yes		–	–	
Codimal DM (alcohol, dye, and sugar free)	yes		–		
contraceptive creams, foams, tablets, sponges, and condoms				–	–
Dramamine . . . . . generic equivalent only		generic equivalent only	–		
DSS caps, liquid, and syrup and concentrate drops 5% (Na+ or Ca++ salt)				–	
ferrous gluconate 325mg, sulfate 325mg/ elixir, 220mg/5c		30 tabs or equivalent	–		
Glucose blood test strips	yes	e.g. Freestyle, Chemstrip, One-touch, Ultra, etc.		–	–

Drug Name	Brand Covered	Limits	N H	NTM	PCN
Glutose	yes		–		
Gyne-Lotrimin		generic equivalent only	–	–	
hydrocortisone cream, ointment, supp.			–	–	
ibuprofen				–	
Imodium AD . . . . . generic equivalent only		generic equivalent only		–	
insulin	yes		–	–	–
insulin syringe with needle-disposable		100/month maximum		–	–
kaolin with pectin suspension					
lancets		100/month maximum		–	–
Lotrimin, Lotrimin AF . . generic equivalent only		generic equivalent only	–	–	
Maalox suspension	yes				
MAG-CARB	yes		–		
milk of magnesia				–	
Monistat-7 generic equivalent only		generic equivalent only	–	–	
Mortrin oral susp. NDC 00045018404			–		
Mortrin drops NDC 50580010015			–		
Mycelex OTC . . . . . generic equivalent only		generic equivalent only	–		
niacin 250mg, 500mg for hyperlipidemia only		(SR, LA forms not covered)	–		
Nix and generic equivalent	yes		–	–	
Pediacare Cough-Cold	yes		–		
Pedialyte liquid and generic equivalent	yes	limited to children through age 10	–		
Pepcid AC (package size ≥ 50)			–	–	
Pepto-Bismol and generic equivalent	yes		–		
Poly Vi Sol		Iron formulations not covered	–		
Prilosec OTC			–	–	
prophylactics, male, female	yes				
pseudoephedrine HCL 30mg, 60mg			–	–	
psyllium muciloid powder			–	–	
Rid and generic equivalents, NDC 74300004140, 74300004120, 74300008200	yes		–	–	
Robitussin . . . . . generic equivalent only		generic equivalent only	–	–	
Robitussin DM . . . . . generic equivalent only		generic equivalent only	–	–	
Senokot 8.6mg tab generic equivalent only			–		
Tagamet HB and generic equivalent,	yes	package size ≥ 30	–	–	
Tavist-1 . . . . . generic equivalent only		generic equivalent only	–		
Triaminic NDC 00043020218; 00043055504; 00043055508	yes	Only these NDC's covered	–	–	
Triaminic AM Cough & Decongestant, NDC 00043055804, and generic equivalents	yes		–	–	
Triminic Cold & Cough, NDC 00043056504; 00043056508 and generic equivalents	yes		–	–	
Triaminic Infant NDC 00043060505	yes			–	
Triaminic Night Time, NDC 00043054804; 00043054808 and generic equivalent			–	–	
triple antibiotic ointment 15gm			–	–	
Tri Vi Sol			–		
urine tests (Clinistix, Clinitest, Diastix, Ketostix)	yes				
Zantac 75, package size ≥ 20			–	–	

05 - 75 Vision Care Services for Non-Traditional Clients: Chapter 2 - 9, Vision Care Clarification of Procedure Codes

Vision exams

Non-Traditional Medicaid clients have coverage for vision screening in conjunction with determining the refraction*. Providers may bill using procedure codes 92002, 92004, 92012, and 92014. There is a maximum Medicaid benefit of $30 for screening services. Charges above the $30 are non-covered Medicaid services and are considered the patient's responsibility.

Care for medical problems of the eye

Services to identify and treat medical problems such as diabetic retinopathy, glaucoma, cataracts, etc., may be billed by ophthalmologists and optometrists using procedures codes 92020, 92083, 92135, 95930, 99201-99205, 99211-99215, 65210, 65220, 65222, 67820, 68761, and 68801. Ophthalmologists may bill additional procedure codes within their scope of service that are covered by Medicaid. These services are paid based on the Medicaid fee schedule and are considered payment in full.

SUMMARY OF VISION CARE BENEFITS

Benefit	Non-Traditional Medicaid Plan (Blue Card)
Vision exams	Eye exams to determine refractions* are limited to one exam every 12 months up to $30. (Use procedure codes 92002, 92004, 92012, and 92014.)
Eyeglasses	Eyeglasses (lenses and frames) are not covered.
Care for medical problems of the eye	Eye exams and eye care to identify and treat medical problems such as diabetic retinopathy, glaucoma, cataracts, etc. are covered. (Use procedure codes 92020, 92083, 92135, 95930, 99201-99205, 99211-99215, 65210, 65220, 65222, 67820, 68761, and 68801.) Medicaid payment is considered payment in full.

*prescription for glasses